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**Examination for tuberculosis is to be completed within 30 days before admission to the Adult Care Center.**

## Report of Tuberculosis Screening Evaluation

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_

1. Date and result of most recent Mantoux tuberculin skin test: Date: \_\_\_\_\_  
Millimeters (mm) of induration: \_\_\_\_\_

2. Check here if previously positive and above information unknown: \_\_\_\_\_

3. Check here if is exhibiting TB-like symptoms: \_\_\_\_\_

4. If TB skin test is 10 mm or greater (5 mm in the HIV-infected), previously positive or if TB-like symptoms exist, **respond to the following:**

a. Date of last chest x-ray evaluation: \_\_\_\_\_

b. Is the chest x-ray suggestive of active TB? (*circle one*) Yes No

c. Were sputum smears collected and analyzed for the presence of Acid Fast Bacilli (AFB)? (*circle one*) Yes No

d. If the answer to 4c is Yes, were three consecutive Smears negative for AFB? (*circle one*) Yes No

5. **Based on the above information, is this individual free of communicable TB? (*circle one*)** Yes No

6. Name of licensed physician, physician's designee or local health department official completing the evaluation:

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Date

Signature: \_\_\_\_\_

**ADULT CARE CENTER OF THE NORTHERN SHENANDOAH VALLEY, INC.**

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